Reaching Out, Inviting In

How Medical Call Centers Can Give Hospitals a Financial Edge in the Age of Transparency and Competition

Prepared by:

Tina Minnick
Director of Business Development

TEAMHealth® MEDICAL CALL CENTER

1431 Centerpoint Blvd., Suite 110
Knoxville, TN 37932
888.203.1118

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Transparency. Developed as a useful tool for consumers, regulators, and payers, public access to a hospital's most intimate operating details is often a bane for administrators.

Since the Centers for Medicare and Medicaid Services (CMS) first introduced HospitalCompare in 2002, the nation's preeminent source for hospital information has grown in relevance, prevalence, and use. Although the site's clinical focus remains intimidating—even out of reach—for the casual visitor, HospitalCompare has enhanced its value proposition with each iteration and upgrade. Detailed data and comparative analysis is available on more than 2,100 hospitals' quality, performance, and perception among customers; comparative information on median Medicare payments to hospitals for common surgical procedures is also now available.

CMS proposals currently receiving Congressional review stand to up the ante on hospital transparency once again. If previous enhancements to HospitalCompare have felt like body blows to providers, Value-Based Purchasing (VBP) will be a kick in the bottom line.

If previous enhancements to HospitalCompare have felt like body blows to providers, Value-Based Purchasing (VBP) will be a kick in the bottom line.

By advancing VBP in Washington, CMS unequivocally warns hospitals of its plans "to transform Medicare from a passive payer of claims to an active purchaser of care."[i] In certain terms, the federal government intends to solidify—and monetize—the relationship between performance and payment. Hospitals that do not keep pace with CMS's stated goals to "drive improvements in clinical quality, patient-centeredness, and efficiency" will pay other hospitals that do so.

As these regulatory measures march inevitably forward, the compounding financial realities of America's patient base continue to spiral downward. The American Hospital Association (AHA) reports that from 2001 to 2007 the cost of uncompensated care in the U.S. rose from $21.5 billion to more than $34 billion. With the advent of global recession in mid-2008, AHA data indicated an 8% increase in hospitals' uncompensated care costs for the third quarter of 2008 compared to the same quarter in 2007.[ii] Swelling of the ranks of uninsured patients and Medicaid participants is expected to continue for some time, as are the corresponding pressures on hospital operations, staffing, and financial performance.

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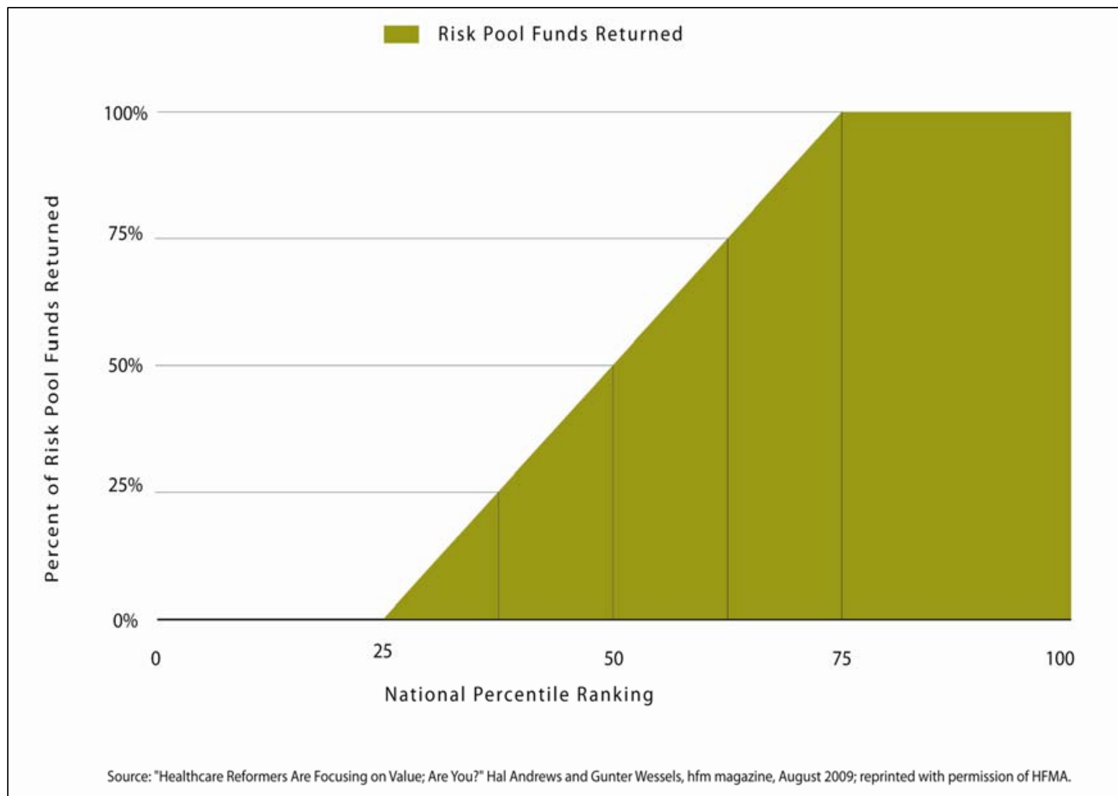
A "Call to Action" recently issued by the Healthcare Finance Management Association (HFMA) predicts "the two most important changes for providers will involve the financial risk of managing a population's health and the technical risk associated with adapting to systems based on quality and efficiency."[iii]

Under VBP, low-ranking hospitals will, in effect, financially reward their better-performing counterparts.

The Looming Impact of VBP

Hospitals will feel the first effects of VBP, if enacted, with the beginning of the new federal fiscal year in October of 2012. At that time, payment adjustments of 2% of Medicare reimbursement will be made and held in a risk pool; withholdings will increase by 1% per year to a cap of 5% in fiscal 2016.

A hospital's ranking in the VBP performance measurement system, which will contemplate both quality and patient satisfaction measures, will determine the portion (if any) of the risk pool funds a hospital receives. A facility with a performance ranking above the 75th percentile will receive risk-pool dollars up to the amount of their withheld reimbursements, plus a small bonus. "Medium grade" hospitals, between the 26th and 75th percentile, will receive a pro rata share of risk-pool dollars, and hospitals falling below the 26th percentile will not receive any risk-pool dollars. Low-ranking hospitals will, in effect, financially reward their better-performing counterparts. The graph below represents the distribution of risk-pool dollars by percentile rankings.



Source: "Healthcare Reformers Are Focusing on Value; Are You?" Hal Andrews and Gunter Wessels, hfm magazine, August 2009; reprinted with permission of HFMA.

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Because evaluation under VBP will be based on a percentile ranking, absolute scores matter less than how a hospital compares relative to all other hospitals. Therefore, it is incumbent upon hospitals not only to maintain their quality and patient satisfaction scores, but also to maintain or improve their overall ranking. Conceivably, a hospital that achieves a ranking in the 76th percentile in one year (receiving its full-risk pool dollars plus a small bonus) could find itself in the 74th percentile the following year even though it achieved the exact same performance scores. Improved performance—and more importantly, improved rank—by its nearest peers in the percentile ranking can cause that hospital with stable performance to lose considerable funds.

The Increasing Importance of Patient Satisfaction

Even without the financial incentive of VBP, patient and community perception of a hospital has long been understood to greatly impact admissions, referrals, recruitment, and even payer arrangements. Under the lens of VBP, however, patient satisfaction scores and their government-issued cousin, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), have an increasingly important impact.

Preventing or recovering one dissatisfied patient requires exponentially fewer resources than recruiting nine new patients.

Although HCAHPS will play a junior role to quality measures in the anticipated VBP weighting system, hospitals would be wise not to overlook the importance of HCAHPS improvement because:

(1) For various reasons, including the relative newness of HCAHPS, many hospitals have a considerable spread between their core measure performance and their HCAHPS performance. In fact, the correlation between the two scores (indeed, between patient satisfaction and quality outcomes generally) is typically low. Narrowing this gap by improving their HCAHPS scores can positively impact a hospital's percentile ranking.
(2) The variance among all hospitals' HCAHPS scores is considerable, and an individual facility has an opportunity to raise its percentile ranking by improving its HCAHPS scores.
(3) Conversely, hospitals are unlikely to impact their rankings with incremental improvements to measures in which variances among facilities are small.

Beyond VBP, improving patient satisfaction can directly impact a hospital's bottom line. Thought leaders in patient satisfaction have long echoed the business axiom that retaining a satisfied customer is more desirable and considerably less resource intensive than losing an unsatisfied customer and replacing them. But the concept of "service recovery" has particularly strong implication in healthcare, where personal referral and "word of mouth" branding are king. Culturally in the United States, it is common, appropriate, and even expected that personal information will be shared after a family member, friend, colleague, or church acquaintance requires medical care in a hospital.

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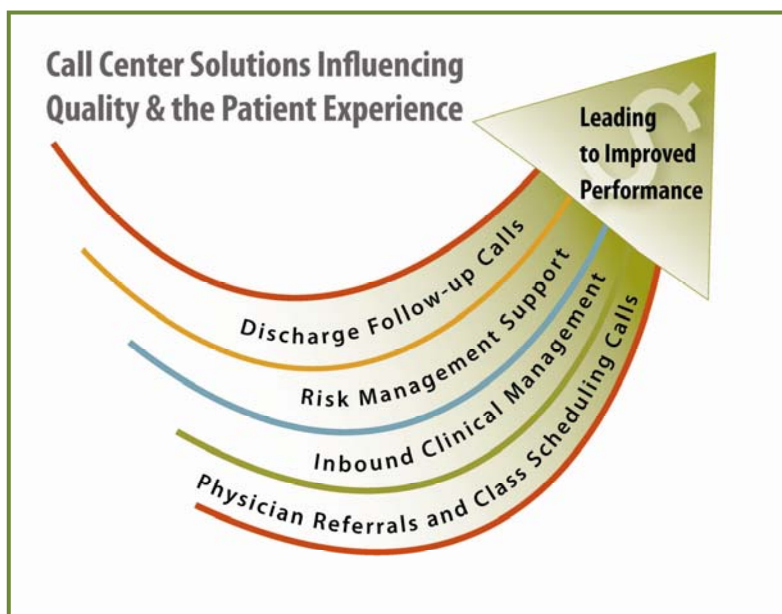
Research first discussed in *The TQM Journal* in 2006 indicates that for every 100 patients who have a negative experience with a provider, approximately 70 would be unlikely to patronize the provider again. Of greater potential damage, as many as 75 of those 100 patients will share their negative impressions with an average of 9 family members and friends. Those 75 dissatisfied customers will likely reach approximately 465 persons.[iv] Clearly, preventing or recovering one dissatisfied patient requires exponentially fewer resources than recruiting nine new patients.

Enhanced Patient Communication as a Solution

In addressing the many issues referenced above, efforts to improve clinical outcomes and contain costs will remain ever-present concerns for administrators, trustees, and hospital consultants. But as consumer and payer priorities continue to converge, top hospitals are identifying robust patient communication programs, such as inbound and outbound patient contact orchestrated through a medical call center, as not only a valuable extension of patient satisfaction efforts, but also as a priority enhancement to patient care, quality outcomes, and risk management measures. The returns can include improved emergency department (ED) outcomes, reduced readmissions, alleviation of employed staff workload, and increased patient satisfaction and HCAHPS scores.



Outbound Communication Management

Discharge Follow-Up Calls

Proactive calls made by clinicians to recently discharged patients provide a unique and meaningful opportunity to extend the patient experience and ensure that "all is well" with the customer. During these calls, trained clinical professionals ask and answer important patient care questions in an effort to reinforce the patient's understanding of discharge instructions or restrictions and ensure compliance with medications or follow-up care. Discharge calls can also serve as a reminder to the patient of their positive experience at the hospital, further confirming the hospital's image in a patient's mind and increasing the likelihood of positive referral in the future.

Research supporting the impact and benefit of discharge follow-up calls is compelling. Meta-analysis conducted by the Alliance for Health Care Research (AHCR) of 29 journal articles published over two decades indicates that "discharge follow-up phone calls provide an

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invaluable opportunity to evaluate patient education, identify trends that may require improvement in practice, improve patient quality of care, determine patients' compliance with discharge instructions, and assess overall impressions of hospital performance."[v] One study included in the AHCR analysis examined 831 patients age 60+ receiving a discharge phone call within 72 hours of an ED visit. The findings revealed:

- 40% required further clarification of discharge instructions
- 31% were advised to return to the ED
- 26% were referred to a medical social worker
- 14% failed to make follow-up appointments[vi]

If appropriately acted upon, the potential medical, operational, and financial implications of these results were likely impactful for the hospital as well as the patients in this study. The Studer Group asserts that healthcare organizations making discharge follow-up calls achieve a 20% to 30% reduction in non-reimbursable readmissions. Further, patients receiving discharge calls place in the 90th percentile as likely to recommend a hospital to friends or family.[vii]

Additional benefits of discharge follow-up calls include:

- Fewer unnecessary return visits to the ED
- Expanded utility of an existing call center or nurse line without additional capital investment
- Decreased liability through better documentation and use of standard guidelines
- Improved tracking of referrals back into the facility
- Increased marketing and brand awareness
- Improved physician satisfaction, aiding in recruitment and retention
- Enhanced opportunity for non-profit hospitals to meet Internal Revenue Service (IRS) community benefit requirements

Although it would be very good if the facility RNs could make these calls, the reality is that they simply don't have time to add this to their task list. Fortunately, there are organizations that provide medical call center functions to hospitals and physician offices. Outsourcing medical call center functions may also achieve:

- Alleviation of ED workload and enhanced throughput, allowing nurses to spend more time on patient care and less time on administrative duties
- Availability of a board-certified physician to provide clinical support and review medical assessments
- Sophisticated and customizable reports for tracking, trending, and utilization studies.

Risk Management Support

Robust medical call centers work closely with a hospital's risk management and clinical teams to identify high-risk discharges and provide proactive calls to patients meriting extra care. This extended outreach can help prevent negative clinical outcomes as well as potential legal exposures.

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Common "red flag" discharges include:

- Patients who leave a hospital Against Medical Advice (AMA) or before ED triage is complete
- Patients who may be a concern because of confusion or dementia
- Patients known to have been medically non-compliant in the past
- Patients who are not appropriate for admission (such as pregnant women, patients with epilepsy or TIA, etc.) but are at risk for continuation or escalation of symptoms
- Pediatric discharges with high fever but no other serious symptoms
- Adults with chest pain but no other cardiac indications (such as patients with GERD)
- Patients who may have received an alarming or disappointing diagnosis
- Patients and/or family members (when appropriate) who seem to have had a negative experience while in the facility

In addition to potentially mitigating the cascading damage of word-of-mouth criticism referenced above, research has shown that the likelihood of litigation decreases when a patient receives a phone call after discharge.[viii]

<u>Inbound Communication Management</u>

Nurse Triage and Patient Assessment

A robust medical call center, whether in-house or outsourced, extends a hospital's relevance into the community. A customer accessing a nurse triage service by phone is demonstrating confidence and initiating (or reaffirming) a relationship with a hospital. It is the hospital's opportunity to solidify the relationship, and there are compelling reasons to do so.

Clearly, the dialogue between nurse and caller gives a hospital the potential to improve the quality of healthcare in the community it serves. Nurse triage representatives can help position hospital service lines and reinforce a hospital's brand messages. The connection may also allow the hospital to increase market share, stimulate cross-selling opportunities, and meet non-profit status requirements.

According to Solucient, call centers generate a return on investment of at least three to one and are an essential driver of hospital revenue, profitability, and patient loyalty. Of note:

- One-in-four callers contacting the call center will have an inpatient discharge or outpatient visit within 12 months of calling.
- Repeat callers use more hospital services than one-time callers.
- Call center callers have higher incomes than non-call center patients (about 25% higher).
- Previous call center callers respond to marketing campaigns at a rate twice that of non-callers.
- Of all callers 71% are women, and 74 percent of all callers are between the ages of 21 and 45.
- Women callers tend to be married and have children.

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- Seniors represent about 18% of callers but account for one-third of all downstream charges.
- Call center callers see their primary care physician (PCP) more often than the overall population, and 80% of callers see their PCP every year compared to 66% of the population overall.[ix]

In addition, round-the-clock patient assessment and triage can significantly impact the ED by enhancing appropriate utilization, thereby decompressing overcrowding while increasing qualified referrals.

Physician Referrals

Beyond patient triage, nurse-staffed call centers can enhance a hospital's relationship with the members of its medical staff. Following a triage call and when appropriate, nurses can send patient reports to the PCP, augmenting the patient-centered medical home.

Medical call centers can also facilitate physician referrals and class scheduling, directly connecting patients or future patients back to a hospital. These kinds of services provide obvious and trackable proof of return on investment, maximizing call center capabilities without additional infrastructure requirement.

CONCLUSION

Like any industry, healthcare experiences whims and short-lived trends from time to time, but transparency in healthcare is not likely to fade away. With the wholesale reach of the Internet into every corner of our personal, professional, and social lives, the explosion of information available to consumers in recent years is staggering, and the methodology and presentation of data from sources such as CMS escalates annually.

Certainly the advent of value-based purchasing attaches a persuasive incentive for improved core measures and HCAHPS performance, but as any hospital that has experienced a negative letter to the editor or defaming remark on a website will attest, the hard and soft costs of patient satisfaction can impact more than just the bottom line. Forward-thinking organizations not only seek to understand the relationship between patient communications and satisfaction, they are forging it.

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[ii] American Hospital Association, *TrendWatch: The Economic Downturn and Its Impact on Hospitals*, pg 5. (January 2009) (accessed September 2009)

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[vi] Christine M. Meade, Ph.D. (2004). Patients, Alliance for Health Care Research, *A Meta-Analysis: Research Supporting Discharge Phone Calls to Hospital*, p. 7. (accessed September 2009)

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